STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085004	A. BUILDING _____ B. WING _____	C 04/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDYWINE NURSING & REHABILITATION CENTER	505 GREENBANK ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced complaint survey was conducted at this facility from April 11, 2018 through April 25, 2018. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 163. The survey sample size was 11. Abbreviations / definitions used in this report are as follows: AA - Activity Assistant; ABT - antibiotic; Acute - of sudden onset; AD - Activity Director; ADLs - Activities of Daily Living/tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing; ADON - Assistant Director of Nursing; AE - Agency employee; AMS - altered mental status; Agitation - emotional state of restlessness; Alprazolam - medication used to treat anxiety; Atorvastatin - medication used to treat high cholesterol; BID - twice a day; BMI - body mass index - measurement of body fat; BNP - Brain Natriuretic Peptide - blood test that shows how well your heart is working; BUN - blood urea nitrogen - blood test that shows how much urea is cleared by the kidneys/diseases which compromise the function of the kidneys will lead to increased BUN; Bystolic - medication to treat high blood pressure; c - with; CNA - Certified Nurse's Aide;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/21/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 Chronic - of long duration; C/O - complaint of; COPD - Chronic Obstructive Pulmonary Disease - inflammatory lung disease; Cachectic - general ill health with loss of weight; Carvedilol - medication used to treat high blood pressure; Cefpodoxime - antibiotic medication to treat infection; Cirrhosis - disease of the liver; Clonidine - medication used to treat high blood pressure; Creatinine - increased quantities found with renal/kidney disease; Cueing - to prompt or remind; D/C - discontinued; DON - Director of Nursing; Dehydration - a condition in which the body has less than normal fluid; Delusional - a belief held with strong conviction despite evidence to the contrary; Dementia - loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning; Deter - to prevent the occurrence of; Diovan - medication to treat high blood pressure; Disorganized thinking - rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject; Dysphagia 1 diet - only pureed foods that require very little chewing; ED - emergency department; Electrolyte balance - equilibrium between the amounts of electrolytes (such as calcium, sodium, potassium) that is essential for normal health and functioning; eMARS - electronic medication administration records; EMS - Emergency Medical Service;	F 000		

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F 000	Continued From page 2	F 000		

Ensure Enlive - liquid supplement;
ENT - Ears Nose Throat;
EtOH - alcohol;
Eliquis - medication to thin the blood;
Encephalopathy - brain disease, damage or malfunction;
F - Family;
FSD - Food Service Director;
Ferrous Sulfate - medication used to treat an iron deficiency;
GFR - process by which the kidneys filter the blood, removing excess water and fluids;
Gram negative bacteremia - specific type of organisms/bacteria present in the blood, which is normally sterile or free of any organisms;
Grievance - an official statement of a complaint over something believed to be wrong or unfair;
hx - history;
Hallucinations - something that seems real but does not really exist;
Honey thick - liquids that have the consistency of honey to prevent choking and stop fluid from entering the lungs;
Hospice - service that provides care to residents that are terminally ill;
Hyperglycemia - high blood sugar;
Hypernatremia - high salt or sodium blood level due to a decrease in total body water;
Hypertension - high blood pressure;
Hypoxia - deficiency in amount of oxygen reaching body tissues
Hypoxemic/hypoxemia - insufficient oxygen for body tissues to function;
IU - international units - measurement for the amount of a substance;
Illogical - lacking sense;
Infiltrate - inside;
Incontinent - loss of control of bladder and/or bowel function;

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F 000	Continued From page 3	F 000		

L - liter - measurement of volume;
LPN - Licensed Practical Nurse;
Lactic acidosis - inadequate clearance of lactic acid from the blood, usually caused by hypoxia.
MAR - Medication Administration Record;
MD - Medical Doctor;
MDS - Minimum Data Set/standardized assessment forms used in nursing homes;
Meds - medications;
mg - milligrams- unit of weight;
mls - milliliter - unit of volume;
Magic cup - nutritional supplement in the form of ice cream or pudding;
Marinol - medication used to treat nausea/vomiting and loss of appetite;
Metoclopramide - medication used to treat nausea/vomiting;
Metoprolol - medication used to treat chest pain and high blood pressure;
Mucosa - inside the mouth;
NAS - no added salt diet;
NC - nasal cannula - tube placed into nostrils to deliver oxygen;
NHA - Nursing Home Administrator;
Nectar thick - liquids that are closer in consistency to a thin liquid and are easily poured;
Neurontin - medication used to treat nerve pain;
Nullo - supplement used to control strong personal odors;
O2 Sat - measurement of oxygen in the blood;
Oz - ounce - measurement of mass;
PO - by mouth;
Pancreatitis - inflammation of the pancreas that produces digestive juices;
Pneumobilia - presence of gas in the biliary system (gallbladder, liver, biliary duct);
Probiotic - supplement that helps with digestive problems;
Psychiatric - relating to mental illness or its

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F 000	Continued From page 4	F 000		

treatment;
Pureed - food that is mashed to the consistency of a creamy paste or thick liquid;
R - Resident;
r/t - related to;
RD - Registered Dietitian;
RN - Registered Nurse;
RP - reporting person;
Res - resident;
SBP - systolic blood pressure/top number of a blood pressure reading;
s/p - status post;
SLP - Speech Language Pathologist - specialist in evaluating swallowing/chewing difficulty;
STAT - immediately;
SW - Social Worker;
Sennokot - medication used to treat constipation;
Seroquel - medication used to treat mental disorders;
Serum - clear fluid obtained from whole blood;
Sodium - a mineral and electrolyte found in salt; blood tests show how much is in blood;
Straight cath - procedure to obtain a urine specimen;
Super cereal/potatoes - fortified foods to increase calories;
UM - Unit Manager;
VS - vital signs;
Vitamin D3 - vitamin used to help absorption of calcium;
Volume depletion - loss of both water and salts from cell volume;
WBC - blood test to measure the number of white blood cells in the blood; high counts are indicative of infection;
wt - weight;
%-percent;
Whipple procedure - complex operation to remove part of the pancreas, part of the small

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F 000	Continued From page 5 intestine and the gallbladder.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced	F 583		6/18/18

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F 583	Continued From page 6 by: Cross refer to F761, examples 1 and 2. Based upon observations and interviews, it was determined that for 2 (R10 and R11) out of 11 sampled residents, the facility failed to protect their privacy and confidentiality of their medical records. Findings include: 1. On 4/24/18 at 11:22 AM in the G Wing hallway, the surveyor observed R10's eMAR displayed on the computer screen of G Wing's medication cart unattended. E26 (LPN) exited a resident's room and returned to the unattended medication cart. E26 stated that she left her medication cart to respond to a resident calling for help. 2. On 4/24/18 at 5:05 PM in the F Wing hallway, the surveyor observed R11's eMAR displayed on the computer screen of F Wing's medication cart unattended. AE4 (LPN) exited a resident's room and returned to the unattended medication cart. AE4 stated that she left her medication cart to assist a resident with toileting. Findings were reviewed with E3 (Staff Educator) on 4/24/18 at 5:15 PM. The facility failed to protect the privacy and confidentiality of R10 and R11's medical records. Findings were reviewed with E1 (NHA) and E2 (DON) on 4/25/18 at 4 PM during the Exit Conference.	F 583	DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction (POC) does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The POC is prepared and/or executed solely because it is required by the provisions of both Federal and State laws. Example 1 A. R10 suffered no untoward effect from the deficient practice. B. All residents have the potential to be affected due to use of the electronic medical record (EMR). C. All licensed staff who utilize the electronic medical record have been in-serviced on the necessity to protect the confidentiality of resident records and the rules concerning protected health information (PHI). Privacy, security, and PHI have been added as regular agenda items at the nursing meetings monthly and reinforced at orientation. D. The unit managers/designee will monitor the security of patient information in order to ensure screens are not left open and unattended daily for 14 days and then weekly times 10 until 100% compliance is achieved. Results will be reported quarterly through the facility QAPI process. Example 2 A. R11 suffered no untoward effect from the deficient practice. B. All residents have the potential to be	

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F 583	Continued From page 7	F 583	affected due to use of the electronic medical record (EMR). C. All licensed staff who utilize the electronic medical record have been in-serviced on the necessity to protect the confidentiality of resident records and the rules concerning protected health information (PHI). Privacy, security, and PHI have been added as regular agenda items at the nursing meetings monthly and reinforced at orientation. D. The unit managers/designee will monitor the security of patient information in order to ensure screens are not left open and unattended daily for 14 days and then weekly times 10 until 100% compliance is achieved. Results will be reported quarterly through the facility QAPI process.	
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced	F 600		7/9/18

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F 600	Continued From page 8 by: Based on observations, clinical record reviews, interviews and review of facility documentation, it was determined that for 2 (R2 and R7) out of 11 sampled residents, the facility failed to ensure both residents were free from abuse. For R2, the facility failed to ensure the resident was free from emotional and verbal abuse during a care conference meeting when facility staff [E7] spoke loudly to R2 and in a demeaning, derogatory manner. Additionally R2 stated that E4 [UM], E8 [SW#1] and E9 [SW#2] mistreated him/her in the meeting. There were a total of 15 staff members present when E7 stated to her staff, in the presence of R2, "to keep the activity sheets with you....even when you go to the bathroom ...wipe you butt ..." Despite 15 facility staff members being present during R2's care conference, not one stopped the abusive treatment of R2 from continuing. Also, facility documentation lacked evidence that the staff involved were suspended during the investigation and lacked evidence of any disciplinary action. For R7, the facility failed to ensure that R7 was free from emotional abuse when multiple wandering residents entered her room unsupervised causing her emotional distress. Findings include: The facility policy titled, "Abuse, Neglect, Mistreatment, Serious Injury, Misappropriation of Property, Injuries of Unknown Origin," last revised 10/14, stated, "...POLICY: 1. Brandywine Nursing and Rehabilitation Center (BNRC) affirms that all persons admitted to the facility shall be treated with respect and dignity...Staff shall assure that resident care and treatment is administered in a safe, professional, and humane manner...DEFINITIONS: (1) 'Abuse' shall mean:...b. Emotional abuse which includes, but is	F 600	Example 1 A. R2 continues to reside in the facility. E4, E7, E8 and E9 were suspended pending the investigation. As of the completion date of this POC, E7, E8, and E9 are no longer employed at the facility. E4 has received abuse and neglect prevention training to include resident rights. A different staff member was assigned to R2 to ensure his social service needs are met. A new Activities Director and a new Social Worker have been hired. R2 is provided a copy of the daily activities schedule. R2's meal selection delivery accuracy has been discussed with him to confirm improvement. B. All residents have the potential to be affected by the deficient practice. C. The Registered Nurse Assessment Coordinator (RNAC)or comparable appropriate representative if the RNAC is unavailable now proctors all care plan meetings to ensure residents are treated with dignity and respect and complaints/concerns are referred for appropriate department follow-up. All staff members received re-education on the prevention of resident abuse, neglect and mistreatment and respecting resident rights immediately following the event. The food service director or designee will confer with the dietitian to ensure residents likes and dislikes are honored. D. The Activities Director/designee will ensure that a copy of the daily activities schedule is provided to residents daily for 14 days, weekly times 10 and then	

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F 600	Continued From page 9 not limited to, ridiculing or demeaning a patient or resident, making derogatory remarks to a patient or resident or cursing directed towards a patient or resident, or threatening to inflict physical or emotional harm on a patient..." 1. Review of R2's clinical record revealed the following: 2/26/18 - The annual MDS assessment stated that R2 was able to express ideas and wants and was understood, and had clear comprehension and understanding of others' verbal content. The MDS also stated that R2 was independent for daily decision making skills and had no behaviors. 3/14/18 5:16 PM - The facility self reported an allegation of abuse for R2 to the State Agency. This incident report stated, "Resident attended his/her quarterly care plan meeting and resident stated that he/she felt intimidated and abused by certain staff in the meeting...DON [E2] and Administrator [E1] interviewed the resident who confirmed his/her perception of the meeting as intimidating and that 'he's/she's always wrong.' Staff members identified have been suspended pending the investigation." Review of the facility's incident report and investigation revealed the following statements: 3/14/18 - A written statement completed by E1 (NHA) stated that he/she had been informed by an anonymous staff person that R2's care conference had been conducted in an inappropriate and disrespectful manner. The statement went on to say that he met in his office with E7 (Activity Director) and the HR (Human	F 600	monthly until 100% compliance achieved. Food service director or designee will ensure meal delivery accuracy occurs daily for 14 days, weekly times 10 then monthly until 100% compliance is achieved. The RNAC or comparable representative will ensure care plan meeting are conducted appropriately on an ongoing basis. All results will be reported at least quarterly through the facility QAPI process. Example 2 A. R7 no longer resides in the facility. B. All residents have the potential to be affected by wandering residents. C. The Interdisciplinary Team (IDT) will conduct a root cause analysis for each wandering resident whose ability to respect boundaries is impaired and discuss interventions appropriate for each resident and implement them as indicated. The new social service employees will ensure appropriate follow-up for each concern documented. Wandering behavior will be recorded in the MAR for residents on an ongoing basis. Concern forms regarding wandering will be reviewed by the IDT for appropriate intervention on an ongoing basis. D. The RNAC or designee will monitor changes to the care plan as recommended by the IDT regarding wandering residents and determine effectiveness. Review of wandering resident MAR documentation and concern forms will occur daily for 14days, weekly times 10 then monthly until 100%	

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F 600	Continued From page 10 Resource) manager (E27). E1 stated he told E7 that staff felt she was inappropriate during the care conference and to prepare a statement of what happened for review. "E7 said that she was stern with R2 and he/she was unable to identify staff that 'did not know what to do in activities.' E1 wrote that shortly after, E2 (DON) informed him that E3 (Staff Educator) had spoken with R2 and asked how care plan meeting went? R2 stated 'that he/she felt mistreated by the staff in that meeting.' E1 wrote that he and E2 went to speak to R2. E1 wrote that R2 stated, "...the activity staff don't know what they are doing, but again I am always wrong. I feel like people do not want me here." When asked who he/she felt mistreated him/her in the meeting, R2 responded E4 (UM), E7 (AD), E8 (SW#1), and E9 (SW#2). E1 wrote that after the interview he informed E6 (ADON) to begin an investigation and that E4, E7, E8, and E9 were informed they were suspended pending an investigation and to provide written statements. 3/14/18 - A written statement completed by E2 stated, "...E3 came to my office visibly shaken and related a discussion she just had with R2 regarding his/her feeling that he/she had been intimidated during care conference and he/she felt he/she had been abused...He/she remarked that 'everyone came in to point out I was wrong'...'they brought in all the activities staff...all of them to tell me I was wrong...' I asked how he/she felt about the meeting and he/she stated 'Intimidated...abused'...". 3/14/18 - A written statement completed by E3 stated, "...R2 wasn't his/her normal self so I asked him/her if he/she was ok and he/she stated 'no' it was another bad meeting. I asked him/her	F 600	compliance is achieved. Results will be reported at least quarterly through the facility QAPI process.	

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F 600	Continued From page 11	F 600		

what meeting...'the monthly meeting'...He/she was visibly upset...R2 stated, '...just tired of this and they shouldn't have attacked him/her it was wrong and its been going on for years.' At that point I had to ask him/her if he/she felt abused, neglected or mistreated and he/she stated 'Yes.' I told him/her I would be right back and went to find E2 to notify him."

3/14/18 - A written statement completed by E8 (SW#1) stated, "...E7 then asked if he had anything for activities. (R2) made a sound and said 'we'd be here forever if I start'...He/she began telling her how she should run/fix her department. R2 then told E7 that several of her staff don't know what activities are going on throughout the day...E7 then called all her staff to the conference room. She asked her staff questions about what R2 reported. She and R2 went back and forth. E9 (SW) and I tried to calm E7. I asked E7 could we let her staff go and they did leave. E4 (UM) borrowed R2's daily calendar and asked him/her what was occurring at a specific time. He/she was unable to recall and E4 explained that it is difficult to remember the entire days activities...E4 asked R2 if he/she is unhappy here, would he/she like us to help him/her find another placement. He/she didn't answer. E9 reminded R2 that he/she hadn't answered E4 and asked what he/she would like us to do..."

3/14/18 - A written statement completed by E9 stated, "...The AD (E7) asked R2 if he/she had any questions or concerns for activities...R2 stated that when he/she asks activity staff about the activities of the day or about changes he/she often gets 'I don't know' responses. AD explained that all of her staff have a copy of the daily agenda and are aware of the changes. AD asked

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him/her for specific staff members that have given him/her this response. R2 reports he/she wasn't able to recall. AD called to her department and asked for all of her staff to report to the conference room...The AD was standing and speaking loudly in the conference room...The AD was still standing and stated 'So just take the agenda with you wherever you go. If you have to go to the bathroom take it with you.' This writer attempted to redirect the AD and stated 'Do not take the agenda to the bathroom.' Activity staff members were dismissed and one staff stated 'Just fold it up and put it in your bra'...UM (E4) asked R2 if she could see his/her daily agenda as he/she also reported during care conference that he/she highlights which activities are of interest...UM asked R2 what the 3:45 activity is. R2 attempted to state the activity but the UM informed R2 that he/she was wrong. He/she attempted 2 more times with the incorrect answer. R2 stated 'pick an activity I have highlighted.' UM informed R2 that the 3:45 activity is one he/she has picked. UM stated 'See (name of R2) . It is not that easy to remember the daily agenda.' UM then discussed with R2 that 'Since he/she is not happy here is there another facility he/she would like a referral too (sic)'...".

3/14/18 - A written statement completed by E4 (UM) stated, "As I was coming down the hall to enter the conference room E9 (SW#2) walked past me and made a comment that it was getting heated in there...E7 (AD) was stand (sic) and speaking loudly at R2 regarding activities. R2 was concerned about staff not knowing the activity schedule when he/she asks them...activity staff and E9 began entering the conference room...Concerned this was continuing to escalate I tried to speak to R2...at this point E7 and E8

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F 600	Continued From page 13 (SW#1) began speaking loudly again. E7 was still standing leaning over the table...E8 stated they have done everything possible and bend over backwards for him/her...At this point I cut in and said to R2 I believe you and I have formed a good relationship and I see you aren't happy what is it we can do to make you happy or are you not happy here anymore? E8 spoke up and said she could help him/her with referrals near family...or another facility in Wilmington. E9 (SW#2) asked him/her to answer my question and he/she said he/she wasn't sure. He/she said he/she needed to speak to his/her family. E9 said he/she is alert and able to make his/her own choices in care. He/she repeated he/she wanted to talk to family...E8 stated he/she had spoken to family before...and since his/her two family members could never make it in the same time because he/she insisted on their presence it was never completed...He/she looked at his/her schedule for a bit and a comment was made about him/her not knowing what he/she wanted to do, I do not recall which staff member said this...". 3/14/18 - A written statement completed by E10 (RD#1) stated, "...R2 stated that his/her meals still were not correct...E8 (SW#1) stated that staff have 'bent over backwards' to ensure his/her order was correct...E7 (AD) asked R2 if he/she had concerns about the activities...R2 stated the activities staff do not know what activities are occurring when he/she asks them, and he/she expressed he/she does not like when the location of the activity is changed because he/she has to move to the different room...E7 raised her voice...E7 continued to speak with a raised voiced (sic) which continued throughout the Care Conference until about when her staff exited the conference room and asked R2 'Who doesn't	F 600		

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F 600	Continued From page 14 know what's going on in activities?' R2 stated he/she didn't want to give names. E7 stated 'Why not? I want to know who doesn't know what's going on.' E7 stood abruptly...she wanted all of her staff to come to the conference room...E7 stated to her staff with a mocking tone of voice 'R2 thinks you all don't know the activity schedule.' The statement went on to say that E7 asked each activity staff aide if they knew what they were doing today. Finally one activity aide stated she did not know and would have to look at the daily activities sheet. E4, E8, and E9 stated to R2 that it would be difficult for any staff member to memorize the entire day's schedule of activities. "...E7 stated to her staff with a continued mocking tone of voice 'You all need to keep this sheet with you every day including going to the bathroom. If you're going number two, wipe your butt with it, I don't care. You need to have it'...At the end, R2 had mentioned carrying the daily activities schedule around with him/her so that he/she could remember. E7 sarcastically responded 'Oh really? Hmmm, you don't remember, huh?' R2 stated 'When you get to be my age you see how much you remember.' " 3/15/18 - An emailed statement from E7 (AD) stated, "...Activity Director did request Activity Assistants to join in the conference so that R2 could better identify the staff that he/she was accusing of not knowing the activities for the day. Resident was unable to do so. During care conference, R2 fluctuated between his/her concerns stating that the activities were horrible then saying they were great. Due to Resident being unhappy with the service at Brandywine, E4 (UM) asked if he would like to return to the community with the assistance of a state assisted	F 600		

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F 600	Continued From page 15 program and R2 avoided the question. Question was asked multiple times before a response was given...". 3/15/18 - Review of a typed statement, dated 3/15/18, revealed that E6 (ADON) conducted an interview with R2 regarding the 3/14/18 care conference. The following was stated during the interview: - A discussion began about activities and R2 stated that activity staff doesn't know what activities are scheduled for the day or where they are; - R2 stated that E7 (AD) didn't like being told certain things and the next thing he knew was all activity staff came in the conference room; - When asked how that made him/her feel, he/she stated it felt like everyone thought he/she was lying; - R2 said he/she felt terrible because they think I'm a liar; - When asked if he/she felt abused, neglected or mistreated and he/she said "just felt terrible"; - When asked how E8 (SW#1) made him/her feel, he/she stated "...terrible like she always does when I talk to her...it's either her way or no way...just like during resident council meetings. She doesn't give you a chance to talk, runs over what you're saying and closes the meeting out because it can't run for too long"; - When asked how E9 (SW#2) made him/her feel, he/she stated "...terrible, she follows the lead, she's just like E8 but wasn't that way when she first came here..."; - When asked if E4 (UM) made him/her feel terrible, he/she stated, "no because she didn't say that much, E4 spoke, not too much in my favor"; - When asked how E7 made him/her feel, he/she stated, "...terrible...feels that everybody thinks	F 600		

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F 600	Continued From page 16 he's/she's lying, and that it's frustrating every day, like they want him/her out of here"; - When asked if he/she were to see E7, E8, E9, E4, or E10 (RD) in the hallway would he/she feel uncomfortable and he/she stated no. The ADON wrote, "...R2 was not on trial but when he/she expressed that activity staff did not know the schedule or schedule changes the activity staff were called to the conference room for R2 to identify the staff he/she was 'accusing.' The resident clearly states that the quarterly care conference caused the resident to feel 'terrible, that everyone thinks I'm a liar' and that R2 is always wrong. The staff in question did not follow the BNRC policy and procedure for abuse, neglect, mistreatment...The resident was not treated with respect and dignity. Emotional abuse includes ridiculing or demeaning a resident, making derogatory remarks to a resident, cursing directed to a resident. Treating a resident in a nursing home in a manner that does not uphold a residents self worth and individuality..." 3/16/18 - A written statement completed by E14 (AA) stated, "...Act. (Activity) Director was with resident and a few other workers as she proceed (sic) to ask me a question which I gave her my answer...Afterwards she began to speak with the resident where there (sic) conversation got little (sic) heated. Act Director said something not so friendly to/in reply to the resident as the conversation gotten (sic) little out of control...". 3/16/18 - A written statement completed by E17 (AA) stated, "Myself and a few other staff members were called to the conference room...E7 (AD) to my view point very abusively was telling R2 that her staff members do not normally carry our newsletters everywhere we go.	F 600		

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F 600	Continued From page 17 However in a very harsh manner she than (sic) told us to carry our newsletters everywhere we go, even if going to the rest room. She sarcastically told us to wipe with it...She continued raising her voice at the resident. R2 was trying to interrupt but the ladies (E7, E9 [SW#2] and E8 [SW#1]) did not let him and continued to try to explain themselves...in my heart I was very upset that I did not have the ability to interrupt the conversation to calm everyone down." 3/16/18 - A written statement completed by E18 (AA) stated, "...Several of the activities staff came in and I felt like we were unwittingly ganging up on R2. E7 (AD) was talking loud and arguing with R2 about people not carrying their daily sheets...She (E7) yelled to R2 so you want me to tell my staff to take the daily sheet/clipboard where ever they go?...Shall I have them take it in when they pee?...E8 (SW#1) I believe said something then. Shall I have them take it in when they have a bowel movement. Okay, I'll have them do that and they can wipe their butts on it. At which point I said eew (sic) loud enough for her to know she had gone too far. Even before that comment I was ready to walk out in protest. E7 was obviously feed (sic) up, but she handled it inappropriately. Being disrespectful, rude and crude. At one point E7 mentioned how R2 forgets sometimes. And he/she said he/she did not. E8 said yes you do, in your last testing you had forgotten some things. I felt that this had little to do with the conversation and could have been talked about more privately with out so many activities people in the room." 3/16/18 - A written statement completed by E19 (AA) stated, "The activities staff was summoned	F 600		

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to the conference room by a call from E7 (AD). Her tone was inpatient/upset...E7 was very agitated and began raising her voice, not only to R2. She said that we should take our clipboards to the bathroom with us and wipe out butts with it. E8 (SW#1) at one point asked E7 to 'reel it in' but the agitation continued. At one point someone, either E9 (SW#2) or E8, asked R2 what was going on that day at 3:00. He/she wasn't able to answer the question, and the point was made that how were we supposed to have it memorized. In my opinion esp.(especially) E7's tone was very abusive to this resident and it was unprofessional and embarrassing...".

3/17/18 - A written statement completed by E16 (AA) stated, "We were called up into the conference room...She (E7) then started to ask R2 questions about the newsletters being very unprofessional say (sic) things on how we should keep out newsletters...".

3/19/18 - A written statement completed by E11 (AA) stated, "...Upon our arrival staff was questioned about the daily schedule...Inappropriate comments from management were made towards residents concern. I'm unsure the reasoning why activity staff was needed and was quit (sic) shocked as to the behavior from management...".

3/19/18 - A written statement completed by E12 (AA) stated, "...During the meeting management made inappropriate comments towards the resident...".

3/19/18 - A typed and signed statement was completed by E13 (AA) and stated, "I was call (sic) to the care plan meeting by Activity Director

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(E7)...I ask (sic) a question why are we in here this is a mess I think the meeting went to a point that it should not have been and things got a little out of hand. E7 was a little upset with the Resident."

3/20/18 - A written statement completed by E15 (AA) stated, "...When I entered the room there were several people all ready there sitting around the table. All the activity assistants, E8 (SW#1), E9 (SW#2), E10 (RD), and R2. E7 was standing on the opposite side of R2. Her voice was raised loudly directed to R2...E7 shouted to R2 'All the activity staff are here. Now point out which one you are having a problem with concerning the activity schedule.' R2 was very quiet when he/she spoke. She (E7) got louder and louder toward R2...This incident was the exact opposite of what we were taught or how a caregiver should conduct their encounter with a resident. R2 was not being treated with respect, consideration or dignity. One very inappropriate comment E7 made that really stuck in my mind was 'from now on all the activity staff will have their schedule and clipboards with them everywhere. They will have to take it to the bathroom when they pee and for all I care they can wipe their butts with it!' I felt shocked, dumbfounded and frozen to my seat. I could not believe what I was hearing. To see a person of authority treating a resident in this manner was unbelievable...".

4/25/18 approximately 1:20 PM - During an interview regarding the 3/14/18 care conference, R2 confirmed that he/she felt "terrible" and they made me feel "like I'm a liar" and "I feel like they want me out of here." When asked if he/she was having any issues with his/her appetite, sleeping or participation in activities, he/she stated, "I have

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F 600	Continued From page 20 big shoulders, but there is only so much you can take." The facility failed to ensure that R2 was free from emotional and verbal abuse during a care conference when facility staff spoke loudly and in a demeaning, derogatory manner. Fifteen staff members, present during the care conference, failed to intervene and stop the abuse of R2. The facility failed to suspend involved staff for the duration of the investigation and failed to discipline the staff. 4/25/18 approximately 4:00 PM - Findings were confirmed by E1 (NHA) and E2 (DON) during the exit conference. 2. Cross refer to F689, examples 1 and 2. Review of R7's clinical record revealed the following: 2/20/18 - R7 was admitted to the facility for long term care. 2/26/18 - The admission MDS assessment revealed that R7 was cognitively intact, required limited assistance of one staff person for bed mobility, and supervision for transfers. 3/8/18 and 3/9/18 - Review of R7's progress notes lacked evidence of two incidents involving R7 and two wandering residents that were submitted on the facility's 3/12/18 Resident and Family Grievance/Concern Form. 3/12/18 - The facility's Resident and Family Grievance/Concern form stated, "...RP (F1) called this AM & complained that 2 residents wandered	F 600		

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F 600	Continued From page 21 into R7's room. Friday night at 1 AM (R8) wandered in while being combative c [with] staff which woke R1. Possibly? Thurs. night a male wandered in c staff who followed him in - he was still able to get on R1's bed...". The Grievance form under Section D. Steps to Resolve Problems stated that the facility offered a stop sign which R1 and F1 agreed to try. Under Section E. Final Disposition, it stated, "...UM (E4) explained that BNRC has residents c [with] all types of needs & staff do their best to deter residents from wandering into other res. rooms. UM obtained stop sign for room." 4/3/18 - Review of an email from F1 to E2 (DON) stated an incident occurred on 4/2/18 involving R1 and R8. The email stated, "...R8 entered the room of R1 on 4/2/18 at approx.[approximtely] 11:30 PM. R1 was asleep in her bed. R8 touched the head of R1 causing her to be awakened and become immediately fearful. R1 put her call bell on to summon staff for assistance. According to R1, R8 resisted being escorted out of the room. When asked what she meant by 'resisted', R1 stated 'physically resisted, that they had to almost drag R8 out of the room'...R1 stated to...F1...this morning that she was scared to death when R8 woke her up by touching her. R7 also stated that she did not believe the stop sign on the entrance door to her room was in place at the time. On previous occasions when confused residents have entered her room staff gave the remedy of closing her door. R7 does not want to have her door closed at night. This is not the first time a confused resident has entered her room at night while she was asleep. Staff have instructed R7 to tell confused residents to 'Go home' when they wander into her room...".	F 600		

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F 600	Continued From page 22 4/3/18 to 4/19/18 - Review of R7's clinical record lacked evidence of a follow-up investigation to the 4/2/18 incident by either nursing staff or the facility's medical social workers to prevent wandering residents from entering R7's room as the current interventions were not effective and caused emotional distress to R7. 4/16/18 at 10:06 AM - Observation of R7's "Stop" sign revealed it was hanging down on one side of her entrance doorframe and not across her doorframe to keep wandering residents from entering. 4/19/18 at 11:22 AM - During a combined interview with F1 and R7, F1 stated that there were multiple incidents with wandering residents. The first incident (unknown date/time) was an unidentified resident who came into R7's room and tossed her personal belongings around in front of R7, who then became upset and F1 stated that she witnessed the tossed items when she arrived at the facility. R7 stated another incident involved R8 who walked into R7's room on 4/2/18 at approximately 11:30 PM turned the light on and approached R7 sleeping in bed and touched her head. R7 woke up to R8 touching her head and was scared, upset and crying. The unidentified CNA who responded laughed and R7 asked "What is so funny?" When the surveyor asked if the nurse came in to check on her that night after the incident, R7 stated "no". When F1 brought this incident to the facility's attention, F1 stated she was told the wanderer, R8, was harmless. F1 stated that R8 was a resident from another wing in the facility and questioned who was watching R8. R7 stated the the facility provided a fabric "Stop" sign attached by velcro across her outside entrance doorframe, but R7	F 600		

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F 600	Continued From page 23	F 600		

stated that the wandering residents just remove it. R7 stated that the facility suggested that she close her door, but R7 prefers to have the door open. Due to the lack of a follow-up investigation from the 4/2/18 incident, the facility failed to identify the staff person who laughed while the incident was occurring, failed to identify the potential for resident to resident abuse and failed to respond appropriately to the incident, causing added emotional abuse to R7.

4/19/18 at 3:20 PM - Observation of R7's "Stop" sign was hanging down on side of entrance doorframe and not across the doorframe to keep wandering residents from entering.

4/19/18 at 11:40 PM - A nurse's note stated, "Approx. 2130 (9:30 PM) I was helping another patient in there (sic) room when I was notified by the NURSE on G WING that this resident (R7) had a C/O being upset due to another resident startling her from wandering in her room. I went to see the resident and she stated, 'This has happened to me two times now.' I observed the Stop sign on her door and asked if she was alright, and would she like anything for comfort. She wanted her door to remain open still and just wanted to continue to rest. I went to make sure that the resident that wandered was assisted by her nurse and aide to her own room."

4/20/18 to 4/22/18 - Review of R7's clinical record lacked evidence of a follow-up investigation to the 4/19/18 incident by nursing staff and/or the facility's medical social workers to prevent wandering residents from entering R7's room as the current interventions were not effective and caused emotional distress to R7.

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	085004	A. BUILDING _____ B. WING _____	C 04/25/2018

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F 600	Continued From page 24 4/23/18 at 8:20 AM - During an interview, R7 stated that last Thursday, 4/19/18, she was asleep in her bed with the door open. R9 (another wandering resident) came into her room and R7 told her to "get out". R9 responded "no". R7 pulled the call bell and stated no one responded immediately. R7 stated she told the resident to "get out" again and R9 responded "no". R9 was at the window. R7 yelled "Help" and the CNAs came running. R7 stated that she was extremely upset. R7 stated that the CNAs were "dragging the resident (R9) out of her room." R7 stated that F1 emailed E2 (DON) the following day. 4/23/18 at 11:38 AM - During an interview, E2 (DON) stated there were no incident reports involving R7 and wandering residents since her admission on 2/20/18. E2 provided copies of R7's grievances, dated 3/12/18 and an email on 4/3/18, which addressed incidents of wandering residents. 4/25/18 at 2:45 PM - Findings were reviewed with E2 (DON). The facility failed to ensure that R7 was free from emotional abuse when multiple wandering residents continued to enter her room unsupervised causing her emotional distress and when a facility staff person laughed during the 4/2/18 incident. 4/25/18 at 4 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference.	F 600		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 610		6/18/18

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F 610	Continued From page 25 §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews, review of facility policy and procedure, and review of employee personnel files, it was determined that the facility failed in response to allegations of abuse, neglect, exploitation, or mistreatment to prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation was in progress. The facility failed to remove four staff (E4 [UM], E7 [AD], E8 [SW#1], and E9 [SW#2]) from working in the facility while an investigation involving R2, regarding an allegation of abuse, was ongoing. Findings include: Cross refer F600, example #1 The facility policy titled, "Abuse, Neglect, Mistreatment, Serious Injury, Misappropriation of Property, Injuries of Unknown Origin," last revised 10/14, stated "PURPOSE: The purpose of this policy is to assure the protection, safety, and well-being of the facility residents...C. To ensure proper...Protection (of our residents) regarding	F 610	A. E4, E7, E8 and E9 were immediately suspended pending the investigation. As of the completion date of this POC, E7, E8, and E9 are no longer employed at the facility. E4, E8 E9 were directed to return to work prior to completion of the investigation on 3/16/18 and resumed their normal schedules. E4, E7, E8, and E9 have since received abuse and neglect prevention training to include resident rights. E6 concluded the investigation on 3/21/18 when the 5-day report was submitted. E8 resigned effective 5/19/18 and E9 resigned effective 4/28/18. B. All residents have the potential to be affected by the deficient practice. C. A facility wide in-service to identify, intervene and prevent abuse, neglect and mistreatment was conducted immediately following the event on March 14, 2018 by staff development. A company-wide review of procedures regarding discipline	

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F 610	Continued From page 26 abuse...REPORTING PROCEDURE:..B. In case of suspected ABUSE, the Unit Manager/Supervisor shall immediately, upon receiving notification of the incident respond in the following manner: 1. Ensure resident's safety...If staff to resident abuse is suspected, staff will immediately be removed from the schedule pending investigation...". 3/14/18 5:16 PM - The facility self reported an allegation of abuse for R2 to the State Agency. This incident report stated, "Resident attended his/her quarterly care plan meeting and resident stated that he/she felt intimidated and abused by certain staff in the meeting...DON [E2] and Administrator [E1] interviewed the resident who confirmed his/her perception of the meeting as intimidating and that 'he's/she's always wrong.' Staff members identified have been suspended pending the investigation." Review of E4's, E7's, E8's and E9's employee personnel files lacked evidence of any suspensions related to the investigation of R2's 3/14/18 care conference . An interview with E1 (NHA) and E2 (DON) was conducted on 4/25/18 at approximately 2:30 PM. E1 and E2 were questioned regarding the lack of evidence of any suspensions or disciplinary actions for E4, E7, E8 and E9 regarding R2's 3/14/18 care conference. E1 and E2 stated that E6 (ADON) was directed to begin an investigation and the four (4) employees were suspended on 3/14/18 after they became aware of the incident. E1 and E2 stated that the four employees did not work on 3/15/18, but on 3/16/18 they returned to work, excluding E7, who had resigned. They stated that when they asked the other three	F 610	action was completed and presented to key members of the organization on April 3, 2018 at the corporate headquarters. D. ADON/investigative officer/designee will monitor each allegation of abuse neglect and mistreatment involving a staff member for compliance with Brandywine policy. Results will be reported at least quarterly through the facility QAPI process.	

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F 610	Continued From page 27 employees why they were back at work, they replied that they were directed to do so by the Corporate office. The facility failed to follow their policy and procedure for the protection of a resident during an ongoing investigation of an allegation of abuse. Findings were confirmed by E1 and E2 during an exit conference on 4/25/18 at approximately 4:00 PM.	F 610		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F 657		7/9/18

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F 657	Continued From page 28 (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to revise the care plan to reflect current resident's needs for two (R8 and R9) out of 11 sampled residents. Findings include: 1. Review of the clinical record revealed the following: 10/24/17 - R2 was admitted to the facility with diagnoses that included dementia. 10/25/17 - A care plan was developed for the problem potential for altered mood state. This care plan stated R8 was fixated on another wandering male resident ,who she believes is her husband, and often follows him which then provokes this other resident. An intervention stated to increase supervision with redirection in regards to this resident wandering with this particular resident. 1/26/18 - A quarterly MDS assessment stated R8 had severe cognitive impairment, disorganized thinking, verbal behavioral symptoms directed toward others, such as threatening others, screaming at others, cursing at others which occurred on 1 to 3 days during the 7 day review time period. This MDS also stated R8 wandered daily and was independently ambulatory. Review of nurse's progress notes from 3/1/18 through 4/21/18 revealed multiple episodes of R8	F 657	Example 1 A. R8 had no untoward effect from the deficient practice. B. All wandering residents have the potential to be affected by the deficient practice. C. The Interdisciplinary Team (IDT) will conduct a root cause analysis for each wandering resident whose ability to respect boundaries is impaired and discuss interventions appropriate for each resident and implement them as indicated. D. The RNAC or designee will monitor changes to the care plan as recommended by the IDT regarding wandering residents and determine effectiveness daily for 14 days, weekly times 10, and then monthly until 100% compliance. Results will be reported at least quarterly through the facility QAPI process. Example 2 A. R9 had no untoward effect from the deficient practice. B. All wandering residents have the potential to be affected by the deficient practice. C. The Interdisciplinary Team (IDT) will conduct a root cause analysis for each wandering resident whose ability to respect boundaries is impaired and	

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F 657	Continued From page 29 wandering into other residents' rooms, taking things, eating their food, and on some occasions becoming combative. The facility failed to review and revise R8's care plan to reflect her above listed behaviors and failed to identify interventions to help manage the behaviors. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 4/25/18 at approximately 4:00 PM. 2. Review of R9's clinical record revealed the following: 9/2/15 - R9 was admitted to the facility with diagnoses that included dementia with behavioral disturbance and delusional disorder. 4/11/17 - R9 was care planned for wandering into other rooms and wandering in the hallway. The interventions included: - redirect as needed; - 1 on 1 as needed; - encourage activities; - return to room or quiet area as needed; - toilet as needed or incontinent care as needed; - give food or fluid; - change position; - adjust room temperature; - backrub; - refer to charge nurse for further intervention; and - psych consult as ordered. 2/19/18 at 2:36 PM - A Social Services note stated that R9 had short and long term memory impairment and wandered daily.	F 657	discuss interventions appropriate for each resident and implement them as indicated. D. The RNAC or designee will monitor changes to the care plan as recommended by the IDT regarding wandering residents and determine effectiveness daily for 14 days, weekly times 10, and then monthly until 100% compliance. Results will be reported at least quarterly through the facility QAPI process.	

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F 657	Continued From page 30 2/29/18 - The quarterly MDS Assessment stated R9 had short-term and long-term memory problems, decisions were poor and required cues and supervision for daily decision making, experienced hallucinations, wandering behavior occurred daily and was independently ambulatory in her room and the corridor. 3/7/18 - Despite R9's continued wandering into other residents room, the facility failed to initiate new interventions and her care plan remained the same. 4/25/18 at 2:45 PM - Findings were reviewed with E2 (DON). The facility failed to revise R9's wandering care plan by initiating new interventions as she repeatedly continued to wander into other residents rooms.	F 657		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ...	F 676		7/9/18

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F 676	Continued From page 31 §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interviews, it was determined that for 1 (R7) out of 11 sampled residents, the facility failed to provide care and services in accordance with an activity of daily living, specifically bathing. Findings include: Review of R7's clinical record revealed the following: 2/20/18 - R7 was admitted to the facility and was scheduled for showers twice a week on Sunday and Thursday evenings. 2/20/18 - R7 was care planned for ADLs with an intervention that included, but not limited to, assisting R7 with showering and/or bathing as per her needs.	F 676	A. R7 no longer resides in the facility. E5 received disciplinary action for failing to provide goods and services and not documenting accurately. B. All residents who require assistance with bathing have the potential to be affected by the deficient practice. C. All nursing staff will be in-serviced no later than June 11, 2018 regarding following shower schedules and correct documentation of care provided. Unit managers or designee will survey a representative sample of 8 residents requiring assistance with bathing to confirm services provided as their cognition allows. D. Unit managers or designee will	

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F 676	Continued From page 32 2/26/18 - Review of R7's MDS admission assessment revealed that she was cognitively intact, did not reject care offered by facility staff and required extensive assistance of one staff person for bathing. 4/19/18 evening shift - Review of R7's CNA ADL Flow Sheet revealed that R7 was provided a shower as per E5's (CNA) documentation. 4/19/18 through 4/23/18 - Review of R7's nurse's notes during this timeframe lacked evidence that R7 refused her scheduled shower on Thursday evening, 4/19/18. 4/23/18 at 8:20 AM - During an interview, R7 stated that she was scheduled for showers on Sunday and Thursday evenings. R7 stated that she did not receive her shower on Thursday evening, 4/19/18. R7 stated that she received a shower on Sunday evening, 4/15/18, and the next shower provided was on the following Sunday evening, 4/22/18. 4/23/18 at 2:28 PM - During an interview, E4 (UM) stated that she heard about R7's lack of shower earlier today and stated that she left a voicemail with E5 (CNA) to call her back about the issue. 4/23/18 at 2:43 PM - During a follow-up interview, E5 stated that she spoke with E4, who stated that R7 refused her shower and she incorrectly documented that R7 had a shower on the CNA ADL Flow Sheet. 4/25/18 at 11:10 AM - During a follow-up interview, R7 stated that she did not refuse a	F 676	monitor shower documentation to ensure accuracy daily for 14 days, weekly times 10 and then monthly until 100% compliance is achieved. Results will be reported at least quarterly through the facility QAPI program.	

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F 676	Continued From page 33 shower. 4/25/18 at 2:45 PM - Findings were reviewed with E2 (DON). The facility failed to provide R7's scheduled shower during the evening shift of 4/19/18. 4/25/18 at 4 PM - Findings were reviewed with E1 (NHA) and E2 during the exit conference.	F 676		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, review of clinical records and interviews it was determined that the facility failed to ensure adequate supervision for two (R8 and R9) out of 11 residents sampled. The facility failed to ensure that R8 and R9, both of whom were known to wander throughout the facility and into other residents' rooms, received adequate supervision to prevent these residents from wandering into other resident's personal spaces and creating the potential for resident to resident abuse. Findings include: 1. Review of R8's clinical record revealed the following: 10/24/17 - R8 was admitted to the facility with	F 689	Example 1 A. R8 had no untoward effect from the deficient practice. B. All wandering residents have the potential to be affected by the deficient practice. C. The Interdisciplinary Team (IDT) will conduct a root cause analysis for each wandering resident whose ability to respect boundaries is impaired and discuss interventions appropriate for each resident and implement them as indicated. D. The RNAC or designee will monitor changes to the care plan as recommended by the IDT regarding	7/9/18

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F 689	Continued From page 34 diagnoses that included dementia. 10/25/17 - A care plan was developed for the problem potential for altered mood state. This care plan stated R8 was fixated on another wandering male resident ,who she believes is her husband, and often follows him which then provokes this other resident. An intervention included for this care plan stated to increase supervision with redirection in regards to this resident wandering with this particular resident. 10/30/17 - The admission MDS assessment stated R8 had severe cognitive impairment (never/rarely made decisions), wandering behavior occurred daily and placed the resident at significant risk of getting to a potential dangerous place (stairs, outside of facility), and that the wandering did not significantly intrude on the privacy or activities of others. The MDS also stated R8 was independently ambulatory in her room and in the corridor. 1/26/18 - A quarterly MDS assessment stated R8 had severe cognitive impairment, disorganized thinking, verbal behavioral symptoms directed toward others, such as threatening others, screaming at others, cursing at others which occurred on 1 to 3 days during the 7 day review time period. This MDS also stated R8 wandered daily and was independently ambulatory. Nurse's progress notes stated the following: 3/2/18 11:00 PM - Remains on 1:1 supervision for safety. 3/4/18 10:30 AM - Continued on one to one supervision for safety.	F 689	wandering residents and determine effectiveness daily for 14days, weekly times 10, then monthly until 100% compliance is achieved. Results will be reported at least quarterly through the facility QAPI process. Example 2 A. R7 no longer resides in the facility, R9 had no untoward effect from the deficient practice. B. All residents have the potential to be affected by wandering residents. C. The Interdisciplinary Team (IDT) will conduct a root cause analysis for each wandering resident whose ability to respect boundaries is impaired and discuss interventions appropriate for each resident and implement them as indicated. The new social service employees will ensure appropriate follow-up for each concern documented. D. The RNAC or designee will monitor changes to the care plan as recommended by the IDT regarding wandering residents and determine effectiveness daily for 14days, weekly times 10, then monthly until 100% compliance is achieved. Results will be reported at least quarterly through the facility QAPI process.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 35 3/7/18 9:25 AM - Found standing over roommate. Roommate stated that her chair was missing and that clothes had been moved out of the chair. The nurse also found R8 playing with her roommates balloons while standing over her. The roommate became very agitated and threatened to hit her. A request to move R8 to another room was made. 3/11/18 10:22 PM - Resident pacing up and down hallways, opens everything she can open, goes in and out of other residents rooms, yells at staff and residents, is disruptive and requires constant supervision. 3/15/18 10:25 PM - Went into other residents rooms and had many other residents upset. 3/16/18 10:49 PM - Resident ambulates through hallways and into other resident rooms, she engages arguments with other residents and staff. 3/16/18 11:35 PM - Resident has disrupted the shift many times by rummaging through drawers, and other residents rooms. She was left in her room eating, then was found in another residents room where she had defecated on the floor. 3/19/18 10:10 PM - Rummages through rooms and any items she passes, taking food. 3/20/18 9:23 PM - Has been collecting brushes in her room and continues to steal food. 3/21/18 10:10 PM - Continues to steal items out of other rooms and off carts, during dinner hour she was found in another residents room eating her food.	F 689		

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F 689	Continued From page 36 3/24/18 8:20 PM - Continues to go into other residents rooms, takes food from med carts, snack carts and out of other resident rooms. She has been cursing staff and residents often. 3/28/18 11:40 PM - Resident noted going into other residents room several times and eating food and drinks, redirected several times with difficulty. 3/29/18 11:04 PM - Likes going to other resident bedrooms and looks through their belongings or eats their foods or snacks. 3/30/18 4:34 pm - Continues on walking around, picking on other residents rooms, gets their food, going through their stuff. 4/7/18 12:00 PM - Spoke with several other residents on different floors, said R8 in and out of their rooms, taking things and waking them up, when approached becomes combative. 4/9/18 3:50 PM - Resident noted wandering into other residents rooms this shift. 4/13/18 7:36 PM - Another resident's family member asked her to remove R8 because she (R8) had opened the door to the conference room while a family gathering was in progress and began to disrobe in front of everyone. 4/19/18 3:01 PM - R8 was observed attempting to pull a fire extinguisher off the wall. Redirection did not work, however an offer of fluids and a snack did. 4/19/18 10:10 PM - The resident was observed entering room G16 (not R8's room) where she	F 689		

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F 689	Continued From page 37 picked up a cup and began drinking before being able to be redirected. Although the facility developed a care plan for altered mood state upon R8's admission to the facility and noted R8's fixation on another resident, they failed to identify that R8 wandered into other residents rooms repeatedly and failed to develop a plan to prevent this from occurring. The potential for resident to resident abuse was present, yet the facility failed to identify that the need for increased supervision of R8 was needed, in an attempt to prevent R8 from entering other resident's rooms. Findings were confirmed by E1 (NHA) and E2 (DON) during the exit conference on 4/25/18 at approximately 4:00 PM. 2. Cross refer to F600, example 2. Review of R9's clinical record revealed the following: 9/2/15 - R9 was admitted to the facility with diagnoses that included dementia with behavioral disturbance and delusional disorder. 4/11/17 created, 3/7/18 last reviewed - R9 was care planned for wandering into other rooms and wandering in the hallway. The interventions included: - redirect as needed; - 1 on 1 as needed; - encourage activities; - return to room or quiet area as needed; - toilet as needed or incontinent care as needed; - give food or fluid;	F 689		

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F 689	Continued From page 38 - change position; - adjust room temperature; - backrub; - refer to charge nurse for further intervention; and - psych consult as ordered. 7/30/17 - A Psychiatric Follow-Up Consult stated that R9 was seen after recent medication changes, has had periods of agitation and very difficult to redirect and illogical thoughts. The plan was to continue to redirect inappropriate behavior and continue to monitor changes in mood and cognition. 11/7/17 - R9's Resident Care Profile stated under the Behavior Section that she wanders and resists care. 2/1/18 to 2/28/18 - Review of R9's Behavior Intervention Monthly Flow Record, documented by her assigned CNAs, revealed that R9 exhibited wandering behavior into others rooms or hallways on 15 out of 28 days. 2/29/18 - The quarterly MDS Assessment stated R9 had short-term and long-term memory problems, decisions were poor and required cues and supervision for daily decision making, experienced hallucinations, physical/verbal/other behavior symptoms occurred 1 to 3 days, wandering behavior occurred daily and was independently ambulatory in her room and the corridor. 2/19/18 at 2:36 PM - A Social Services note stated that R9 had short and long term memory impairment, continued to be physically and verbally combative towards staff, was combative	F 689		

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F 689	Continued From page 39 with an outside lab technician on 2/13/18 and wanders daily. 3/1/18 to 3/31/18 - Review of R9's Behavior Intervention Monthly Flow Record revealed that R9 exhibited wandering behavior into others rooms or hallways on 12 out of 31 days. 3/7/18 - R9's care plan for wandering was reviewed and interventions remained the same. 4/1/18 to 4/23/18 - Review of R9's Behavior Intervention Monthly Flow Record revealed that R9 exhibited wandering behavior into others rooms or hallways on 2 out of 23 days. The Flow Record failed to account for R9's wandering incident on 4/19/18 during the 3-11 PM shift. 4/19/18 at 11:36 PM - A Nurse's Note stated that R9 wandered into another resident's room. While staff attempted to redirect R9, she became combative, hitting, scratching and swinging at multiple staff members. R9 was currently in her room with safety measures in place. 4/23/18 at 8:20 AM - During an interview, R7 stated last Thursday, 4/19/18, that she was asleep in her bed in the G wing with the door open. R9, a resident from F wing, came into her room and R7 told her to get out. R9 responded no. R7 pulled the call bell and stated no one responded immediately. R7 stated she told R9 to get out again and R9 responded no. R9 was at the window. R7 yelled "Help" and the CNAs came running. R7 stated that she was extremely upset. R7 stated that the CNAs were "dragging the resident (R9) out of her room". 4/25/18 at 2:45 PM - Findings were reviewed with	F 689		

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F 689	Continued From page 40 E2 (DON). Although the facility care planned and were documenting R9's wandering behaviors into other residents rooms repeatedly, the facility failed to identify the potential of resident to resident abuse by providing adequate supervision for R9 in an attempt to prevent her from entering other residents rooms.	F 689		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on clinical record review, interviews, review of facility documentation and hospital records, it was determined that for one (R1) out of 11 sampled residents, the facility failed to ensure that R1 maintained acceptable	F 692	A. R1 no longer resides in the facility. B. All residents have the potential to be affected by the deficient practice. C. The registered dietitian/designee will review residents with hydration concerns	7/9/18

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F 692	Continued From page 41 parameters of nutritional status, specifically electrolyte balance, and failed to offer sufficient fluid intake to maintain proper hydration according to his estimated daily fluid requirements when R1's diet changed on 2/28/18 requiring nursing staff to provide honey-thickened fluids via a spoon for swallowing safety. R1 was hospitalized on 3/6/18 with diagnoses that included, but not limited to, hypernatremia and acute kidney injury. This deficient practice resulted in harm to R1. Findings include: Review of R1's clinical record revealed the following: 6/28/16 - R1 was admitted to the facility with diagnoses that included alcoholic-induced persisting encephalopathy/dementia, alcoholic cirrhosis of the liver without ascites, chronic pancreatitis, history of a 2007 Whipple procedure and COPD. 1/3/18 - R1's nutritional risk care plan was reviewed with interventions that included the following: monitor food and fluid preferences, provide assistance as needed with food/fluids, and monitor for signs and/or symptoms of diet/supplement intolerance. 1/31/18 - R1 was care planned for being at risk for dehydration with interventions that included: encourage fluid intake from meal tray and between meals; monitor for signs and/or symptoms of dehydration: change in mental status, poor skin turgor, decreased urinary output, dry mucous membranes, dizziness when standing/sitting; monitor labs if ordered; assist with fluid intake as needed; and weight as per protocol.	F 692	to ensure appropriate volume of fluid is recommended. Speech therapy/designee will review those residents identified with swallowing impairment to ensure appropriate consistency and delivery of fluids is recommended. The electronic medical record will be amended to include an additional data field to document that fluids were encouraged and to more accurately reflect intake. All staff will receive training regarding documentation of fluid intake. Results will be discussed during the weekly High Risk meeting by the IDT. Those residents identified as potentially unable to meet current recommendations will be referred to the attending physician for further review. D. Registered dietitian/designee and speech therapist/designee will track those residents identified as being unable to meet current recommendations to ensure hydration needs are addressed by the physician as recommended by the IDT daily for 14days, weekly times 10, then monthly until 100% compliance is achieved. Results will be reported at least quarterly through the facility QAPI process.	

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F 692	Continued From page 42 2/9/18 at 6:36 AM - R1's facility labs revealed the following: - creatinine was 0.6 (normal range was 0.5 - 1.5), - sodium was 142 (normal range was 135-145), - BUN was 17 (normal range was 10-26), and - GFR was 136 (Level 90 or more was Stage 1 - healthy kidneys). 2/16/18 at 8:37 AM - The Nutrition Assessment stated that R1 was on a NAS diet, pureed texture, nectar thick liquids; 75-100% meal intake; received Ensure Enlive three times a day as a supplement and his intake was 100%; had chewing and swallowing problems; and his estimated nutritional requirements for fluid intake was 2255-2600 mls per day. The nutrition plan stated, "...resident continues to lose wt with 4.1% loss this month. BMI underwt for his age. He eats 75-100% of meals and drinks mostly 100% of his Ensure Enlive...Wt loss may be r/t cirrhosis. He also receives magic cup at lunch and dinner. Fluids usually 600ml or greater. He receives 8oz of nectar water between all meals for additional fluids r/t thickened liquids. Labs reviewed. Observed resident during lunch meal, ate very well and was able to feed self. Will add double portions with meals to provide additional calories and protein and avoid further weight loss." 2/23/18 at 12:12 AM - R1 was admitted to the hospital for shortness of breath and change in mental status. His admission labs were: - BNP = 500 high (range 0-177), - BUN was 27 high (range 8-22), - creatinine was 0.80 (range 0.70-1.30), and - sodium was 145 (range 136-146). 2/24/18 at 9:58 AM - A hospital progress note	F 692		

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F 692	Continued From page 43 stated, "...Poor nutrition...seems to have POOR PO intake...Speech did evaluate him yesterday 1) Dysphagia 1 diet with honey thick liquids- ALL PO VIA SPOON 2) Choking precautions 3) 1:1 feeding assist- pt may need verbal cues to swallow due to oral holding 4) Meds crushed in puree...". 2/27/18 at 7:38 AM - R1's hospital labs prior to discharge were as follows: - sodium was 145, - BUN was 19, and - creatinine was 0.61 low. 2/27/18 at 3:14 PM - The hospital's Discharge Summary stated that R1 had the following discharge diagnoses: acute hypoxemic respiratory failure, gram-negative bacteremia, healthcare-associated pneumonia, COPD, pneumobilia and alcoholic cirrhosis of liver. 2/27/18 at 6 PM - R1 was readmitted to the facility. 2/27/18 - R1 was care planned for the Pneumonia diagnosis and antibiotic ordered with an intervention that included to encourage fluid intake if not contraindicated. 2/27/18 at 11:38 PM - A nurse's readmission note stated that R1's "oral mucosa moist and pink". 2/28/18 at 7:50 AM - The re-admission Nutrition Assessment stated that R1's estimated nutritional requirements for fluid was 1800 - 2100 mls per day. The nutrition plan stated, "s/p hospitalization r/t pneumonia. Continues on ABT and probiotic. Per previous assessment, resident started on double portions with meals r/t continued weight	F 692		

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F 692	Continued From page 44 loss to provide additional calories/protein. Observed resident during lunch today. Ate 100% of meal, does require cueing to slow down...Resident is now being downgraded per SLP to honey thick liquids. Will D/C Ensure Enlive and instead add super cereal..., super potatoes at lunch and dinner..., and Ensure pudding BID.... Resident also receives magic cup at lunch and dinner...". 2/28/18 to 3/6/18 - R1's clinical record lacked evidence that fluids were encouraged. 2/28/18 at 10:45 AM - A nurse's note stated that R1 had moist oral membrane. 2/28/18 at 3:10 PM - A Speech Therapy note stated, "Diet changed to puree diet with honey thick liquids, from nectar thick liquids. Liquids to be given via spoon, for safety. Patient to receive verbal cues and prompts with swallowing; as well as verbal cues to decrease rate of intake. Meds crushed in puree. Spoke with nurse in regards to recommendations...". 2/28/18 at 11:17 PM - A nurse's note stated that R1 had moist oral membrane. 3/1/18 at 10:30 AM - A nurse's note stated that R1 had moist oral membrane. 3/1/18 at 11:31 PM - A nurse's note stated that R1 had moist oral membrane. 3/2/18 - R1's ADL care plan was revised and stated that he required supervision with meals after set-up. The facility failed to revise R1's care plan on 2/28/18 when his needs changed requiring facility staff to provide honey-thickened	F 692		

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F 692	Continued From page 45 fluids via a spoon for swallowing safety. 3/2/18 at 3:39 AM - A nurse's note stated that R1's mucus membrane was pink and moist. 3/5/18 at 11:20 AM - A nurse's note stated that R1 had a moist oral membrane. 3/5/18 (updated) - The CNA's Resident Profile for R1 under the Fluid section lacked evidence of specific care and services to be provided to R1, specifically it lacked the services to 1) encourage fluids, 2) failed to identify the type of thickened liquid he required with safety precautions, and 3) a hydration program at 10 am, 2 pm and 8 pm for R1. The Meals section stated to "See Nurse" for diet. 3/6/18 at 2:55 AM - A nurse's note stated that R1's mucous membranes were pink and moist. 3/6/18 at 12:10 PM - A nurse's note stated that R1 was "unable to tolerate PO medications and unable to respond to verbal stimuli...". The physician ordered STAT labs and to obtain a urine sample by straight cath if necessary. 3/6/18 at 2:33 PM - A nurse's note stated that a urine sample was unable to be obtained. 3/6/18 at 2:58 PM - A nurse's note stated that R1 was "...unable to tolerate PO medications and unable to respond to verbal stimuli. MD made aware...Lab lady seen drawing stat labs." 3/6/18 on 3-11 PM shift Late Entry documented on 3/7/18 at 12:05 AM - A facility nurse's note stated, "At start of shift, resident was in bed with eyes open. Was not responding or making eye	F 692		

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F 692	Continued From page 46 contact. VS were 138/80 (blood pressure), 98.2 (temperature), 90 (heart rate), 18 (respirations), 91% on 4 L via NC. Sat resident up in bed and attempted to give him water. He was not responsive or cooperative with fluid intake, would not make eye contact. Took O2 sat again and it was 88% on 4L. Made MD aware. Sent to (hospital) for evaluation via 911 transport. RP made aware." Review of the February and March 2018 eMARs of R1's fluid intake during meals only and monitored by nursing staff from the 2/27/18 readmission to his 3/6/18 hospitalization at 6 PM revealed the following: - 2/27/18 = 720 mls plus 50 mls from Ensure Enlive supplement, total fluid intake was 770 mls (accounted for 43% of his minimum 1800 mls estimated fluid requirements for the day). - 2/28/18 = 840 mls plus 480 mls from Ensure Enlive supplement, total fluid intake was 1320 mls (73%). - 3/1/18 = 960 mls (53%). - 3/2/18 = 960 mls (53%). - 3/3/18 = 840 mls (47%). - 3/4/18 = 960 mls (53%). - 3/5/18 = 720 mls (40%). - 3/6/18 = 120 mls (15%). Despite monitoring R1's fluid intake from his daily meals, the facility failed to identify that R1's fluid intake was not meeting his minimum daily fluid needs (1800 - 2100 mls per day) after his 2/27/18 readmission to the facility when his diet changed requiring staff to provide honey-thickened fluids via a spoon for swallowing safety. The facility lacked evidence that honey-thickened fluids were encouraged and provided between meals. 3/6/18 at 5:17 PM - 911 was called for a change	F 692		

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F 692	Continued From page 47 in R1's mental status and difficulty breathing. 3/6/18 at 6:13 PM - The hospital's ED physician note stated, "...History of Present Illness: 63 y/o male with hx of EtOH related dementia presents from (facility) with AMS, hypoxia...unable to give a history...Collateral hx - via RN said EMS were unable to get much information from (facility) staff - they were not familiar with the patient and his paperwork does not show much more. Hx of COPD. Recent cefpodoxime on MAR from (facility) - not completed course yet...Physical Exam...cachectic...dry tongue...no edema...Final Impression: End stage liver disease...Serum sodium elevated.". 3/6/18 at 6:21 PM - The hospital's labs revealed the following: - sodium was 163 critical (136-146); - BUN was 60 high (8-22); - creatinine was 1.44 high (0.70-1.30); and - WBC was 15.7 high (3.9-10.6). 3/6/18 at 10:18 PM - The hospital's Goals of Care Discussion with R1's family stated, "...The patient has had progressive decline over several months due to progressive dementia. Now presented with severe dehydration in the setting of poor oral intake...discussed that his dementia is progressing and is likely end stage, they do not wish to have aggressive care for him because it will not correct the underlying process. Their focus is to keep him comfortable and are willing to transition him to hospice care...". 3/7/18 at 1:02 AM - The hospital's History and Physical stated, "...Patient is nonverbal at baseline...referred to the emergency room tonight because of hypoxemia, altered mental	F 692		

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F 692	Continued From page 48 status...Patient has been on Cefpodoxime for pneumonia per his outpatient...records. Presents...emergency room where he is noted to have acute kidney injury, lactic acidosis, hypertension, hypernatremia and hyperglycemia, chest x-ray revealing a right lower lobe infiltrate despite outpatient oral antibiotics...Physical Exam...eyes open, looking towards the examiner, not following simple commands...cachectic in appearance, frail, ill-appearing...ENT dry mucosa...Assessment/Plan: Pneumonia...End stage liver disease...Serum Sodium elevated: Hypernateremia related to his acute kidney injury, dehydration, volume depletion...Acute Kidney Injury: ...related to...above. Sepsis, dehydration, volume depletion...Dementia...COPD...". 3/7/18 at 10:31 AM - The facility's STAT labs for R1 (collected on 3/6/18 at 2:21 PM prior to his hospitalization) were: - creatinine was 1.2, - sodium was 164 High, - BUN was 60 High, - GFR was 61.1 (Level 60 - 89 was Stage 2 - kidney damage and mild decrease in GFR), and - WBC was 14.7 High (range was 4.8-10.8). 4/25/18 at 11:30 AM - During an interview, E20 (RD #2) stated that R1 was on the facility's Nourishment List to receive 8 oz of honey thickened water at 10 AM, 2 PM and 8 PM. When E20 was asked to provide evidence of how much R1 consumed of the honey thickened water three times a day via a spoon as R1 required staff supervision for safety, E20 could not provide further information. While the surveyor was provided with a copy of the facility's Nourishment List, printed with the date of 4/25/18, with R1 listed to receive 8 oz of honey-thickened water	F 692		

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F 692	Continued From page 49 between meals, the facility lacked evidence of R1's actual consumption of the fluids to meet his minimum fluid requirement of 1800 mls per day. 4/25/18 at 2:45 PM - Findings were reviewed with E2 (DON). Even with the consideration of R1's comorbidities, decline over the past several months and his current acute illness (pneumonia), the facility failed to identify that R1 was not meeting his minimum daily fluid needs (1800 - 2100 mls per day) after his 2/27/18 readmission to the facility when his diet changed requiring staff to provide honey-thickened fluids via a spoon for swallowing safety. 4/25/18 at 4 PM - Findings were reviewed with E1 (NHA) and E2 during the Exit Conference.	F 692		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the	F 756		7/9/18

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F 756	Continued From page 50 attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Cross refer to F757 Based on clinical record review and interview, it was determined that for one (R7) out of 11 sampled residents, the facility's pharmacist failed to identify and report irregularities with respect to R7's monthly drug regimen review to the attending physician and the director of nursing. Findings include: Review of R7's clinical record revealed the following: 2/20/18 - R7 was admitted to the facility with a diagnosis of high blood pressure. 2/20/18 - R7's admission physician orders stated the following:	F 756	A. R7 no longer resides in the facility. B. All residents requiring blood pressure and/or heart rate monitoring before receiving medication have the potential to be affected. C. A 100% audit of all residents on medications requiring blood pressure and/or heart rate monitoring will be conducted by the pharmacy consultant monthly. Those residents with these parameters will be identified and the physician will be consulted to determine appropriateness of parameter. Concurrently, the pharmacy consultant will audit for compliance with these parameters where indicated. D. Unit managers will audit a representative sample of 8 residents	

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F 756	Continued From page 51 - Bystolic tablet - give 1 tablet daily for hypertension with the parameters to hold the medication for SBP less than 100 and heart rate less than 60; and - Diovan tablet - give 1 tablet daily for hypertension with the parameters to hold the medication for SBP less than 100 and heart rate less than 60. 3/5/18 - The facility's pharmacist completed R7's drug regimen review and noted no irregularities. The facility's pharmacist failed to identify and report that R7's heart rate was not being consistently monitored prior to receiving two anti-hypertensive medications with physician ordered parameters. 4/4/18 - The facility's pharmacist completed R7's drug regimen review and again failed to identify and report that R7's heart rate was not being consistently monitored prior to receiving two anti-hypertensive medications with physician ordered parameters. 4/23/18 at 2:58 PM - During an interview, findings were reviewed with E2 (DON). The facility's pharmacist failed to identify and report the inconsistent monitoring of R7's heart rate as per physician ordered parameters prior to administering two anti-hypertensive medications after completing two monthly drug regimen reviews.	F 756	receiving medications requiring blood pressure and/or heart rate monitoring daily for 14 days, then weekly times 10, then monthly until 100% compliance is achieved. Results will be reported at least quarterly through the facility QAPI process by both the Unit Managers and the pharmacy consultant.	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	F 757		7/9/18

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F 757	Continued From page 52 drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that for one (R7) out of 11 sampled residents, the facility failed to ensure that R7's drug regimen was free from unnecessary drugs, specifically related to inadequate monitoring and inadequate indication for its use. The facility failed to consistently monitor R7's heart rate as per physician ordered parameters from February 20, 2018 through April 19, 2018 before administering two anti-hypertensive medications. Findings include: Review of R7's clinical record revealed the following: 2/20/18 - R7 was admitted to the facility with a diagnosis of high blood pressure.	F 757	A. R7 no longer resides in the facility. B. All residents requiring blood pressure and/or heart rate monitoring before receiving medication have the potential to be affected. C. A 100% audit of all residents on medications requiring blood pressure and/or heart rate monitoring will be conducted by the pharmacy consultant monthly. Those residents with these parameters will be identified and the physician will be consulted to determine appropriateness of parameter. Concurrently, the pharmacy consultant will audit for compliance with these parameters where indicated. D. Unit managers will audit a representative sample of 8 residents	

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F 757	Continued From page 53 2/20/18 - R7's admission physician orders stated the following: - Bystolic tablet - give 1 tablet daily for hypertension with the parameters to hold the medication for SBP less than 100 and heart rate less than 60; and - Diovan tablet - give 1 tablet daily for hypertension with the parameters to hold the medication for SBP less than 100 and heart rate less than 60. 2/20/18 to 2/28/18 - Review of R7's February 2018 eMAR and Progress Notes revealed the following: - Bystolic medication given during the morning medication pass lacked evidence of monitoring R7's heart rate prior to administration on 2 out of 7 days (2/27 and 2/28). - Diovan medication given during the evening medication pass lacked evidence of monitoring R7's heart rate prior to administration on 3 out of 7 days (2/26, 2/27 and 2/28). 3/1/18 to 3/31/18 - Review of R7's March 2018 eMAR and Progress Notes revealed the following: - Bystolic medication given during the morning medication pass lacked evidence of monitoring R7's heart rate prior to administration on 29 out of 31 days (3/1 through 3/10, 3/12 through 3/24, and 3/26 through 3/31). - Diovan medication given during the evening medication pass lacked evidence of monitoring R7's heart rate prior to administration on 29 out of 31 days (3/1 through 3/13, 3/15 through 3/29, and 3/30). 4/1/18 to 4/19/18 - Review of R7's April 2018 eMAR and Progress Notes revealed the	F 757	receiving medications requiring blood pressure and/or heart rate monitoring daily for 14 days, then weekly times 10, then monthly until 100% compliance is achieved. Results will be reported at least quarterly through the facility QAPI process by both the Unit Managers and the pharmacy consultant.	

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F 757	Continued From page 54 following: - Bystolic medication given during the morning medication pass lacked evidence of monitoring R7's heart rate prior to administration on 17 out of 19 days (4/2 through 4/7, 4/9 through 4/19). - Diovan medication given during the evening medication pass lacked evidence of monitoring R7's heart rate prior to administration on 6 out of 7 days (4/1 through 4/4, 4/6, 4/7). 4/23/18 at 2:58 PM - During an interview, findings were reviewed and acknowledged with E2 (DON). The facility failed to consistently monitor R7's heart rate as per physician ordered parameters from February 20, 2018 through April 19, 2018 before administering two anti-hypertensive medications.	F 757		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for	F 761		6/18/18

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F 761	Continued From page 55 storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Cross refer to F583, examples 1 and 2. Based on observations and interviews, it was determined that for 3 out of 3 medication carts observed, the facility failed to keep medications under safe and secure storage with limited access and failed to keep medication carts under direct observation of authorized staff in areas where residents could access them as the potential for more than minimal harm existed. Findings include: 1. An observation on 4/24/18 at 11:22 AM in the G wing hallway revealed an unattended unlocked G wing medication cart with two clear cups containing medications on top of the cart and R10's eMAR displayed on the computer screen. The first cup (approx. 6-8 oz) contained an assortment of pills and the second medication cup contained one pill. E26 (LPN) exited a resident's room and returned to the unattended medication cart. E26 stated that she was responding to a resident calling for help. E26 stated that she was orienting another nurse who happened to be on lunch break at the time. When asked by the surveyor whose medications were in the cups, E26 stated that some pills were left in a medication cup in the top drawer from a (unidentified) resident that refused them earlier and she placed them in the first cup. E26 stated	F 761	Example 1 A. R10 suffered no untoward effect from the deficient practice. B. All residents have the potential to be affected due to medication administration needs. C. All licensed staff who provide medications have since been in-serviced on proper medication administration. Proper medication administration has been added as a regular agenda item at the nursing meetings monthly and is reinforced at orientation. This includes maintaining the security of the medications by locking the cart when unattended. D. The staff developer/designee will observe all licensed staff who pass meds in order to ensure medications are not left unattended and carts are appropriately locked by June 11, 2018 to ensure 100% compliance is obtained. Results will be reported quarterly through the facility QAPI process. Example 2 A. R11 suffered no untoward effect from the deficient practice. B. All residents have the potential to be affected due to medication administration	

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F 761	Continued From page 56 she was picking up the loose pills in the medication cart drawer and placing them in the first cup. When asked whose pill in the second cup belonged to, E26 could not remember immediately. The surveyor then asked the nurse to bring both cups with the medications in them to E4 (UM) so we could identify each pill and dosage individually. The first cup contained 12 pills listed below: - Sennokot 8.6mg - 2 tablets - Seroquel 100mg - 1 tablet - Aspirin 81mg - 2 tablets - Marinol - 1 tablet **Controlled Medication** - Nullo - 1 tablet - Carvedilol 25mg - 1 tablet - Alprazolam 1mg - 1 tablet **Controlled Medication** - Metoclopramide 10mg - 1 tablet - Ferrous Sulfate 325mg - 1 tablet - Vitamin D3 1,000IU - 1 tablet The second cup contained 1 pill listed below: - Clonidine 0.2mg - 1 tablet. Once each pill was identified, E4 disposed of the medications and confirmed the findings with the surveyor. The facility failed to keep medications safe and secure, including 2 Controlled Medications, and the medication cart locked when unattended. Findings were reviewed on 4/25/18 at 4 PM with E1 (NHA) and E2 (DON) during the Exit Conference. 2. An observation on 4/24/18 at 5:05 PM in the F wing hallway revealed an unattended unlocked F wing medication cart with one clear cup	F 761	needs. C. All licensed staff who provide medications have since been in-serviced on proper medication administration to include timeliness. Proper medication administration has been added as a regular agenda item at the nursing meetings monthly and is reinforced at orientation. This includes maintaining the security of the medications by locking the cart when unattended. D. The staff developer/designee will observe all licensed staff who pass meds in order to ensure medications are not left unattended and carts are appropriately locked by June 11, 2018 to ensure 100% compliance is obtained. Timeliness of medications will also be reviewed at the time of the audit. Results will be reported quarterly through the facility QAPI process. Example 3 A. E wing residents suffered no untoward effect from the deficient practice. B. All residents have the potential to be affected due to medication administration needs. C. All licensed staff who provide medications have since been in-serviced on proper medication administration. Proper medication administration has been added as a regular agenda item at the nursing meetings monthly and is reinforced at orientation. This includes maintaining the security of the medications by locking the cart when unattended. D. The staff developer/designee will	

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F 761	Continued From page 57 containing medications on top of the cart and R11's eMAR displayed on the computer screen. The cup contained 4 pills. AE4 (LPN) exited a resident's room and returned to the unattended medication cart. AE4 stated that she was assisting a resident with toileting. When asked by the surveyor whose medications were in the cup, AE4 stated R11. The cup contained the following 4 pills: - Neurontin 100mg - 1 tablet - Metoprolol 25mg - 1 tablet - Eliquis 5mg - 1 tablet - Atorvastatin 20mg - 1 tablet When reviewing each pill with AE4, she stated that R11 does not receive Atorvastatin until bedtime so she removed the pill from the cup and disposed of it in front of the surveyor. Findings were immediately confirmed with AE4. The facility failed to keep medications safe and secure and failed to lock the medication cart when unattended. Findings were reviewed with E3 (Staff Educator) on 4/24/18 at 5:15 PM. 3. An observation on 4/24/18 at 5:10 PM outside the Elsmere dining room revealed an unattended unlocked E wing hallway medication cart. E27 (LPN) and the nurse orientee returned to the unlocked medication cart from the Elsmere dining room. Findings was immediately confirmed with E27. The facility failed to keep the E wing medication cart locked when unattended.	F 761	observe all licensed staff who pass meds in order to ensure medications are not left unattended and carts are appropriately locked by June 11, 2018 to ensure 100% compliance is obtained. Results will be reported quarterly through the facility QAPI process.	

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F 761	Continued From page 58 Findings were reviewed with E3 (Staff Educator) on 4/24/18 at 5:15 PM.	F 761		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview and one out of two test tray results, it was determined that the facility failed to provide food that was served at an appetizing temperature and palatable. Findings include: 4/16/18 at 4:20 PM - During an interview, R7 stated that by the time her three meals, including her coffee, were delivered as she was the last room to be served, her meals were cold. R7 stated that she brought the problem to facility's attention multiple times. The facility responded by attempting different interventions to ensure she received hot meals, for example stating on her meal ticket to reheat her food before she was served and hand delivering her meal tray directly from the kitchen instead of placing her meal tray on the delivery cart. R7 stated that the meals would be better for one day after she would address the issue with the facility, but she was not consistently served hot meals even after the new interventions were initiated.	F 804	A. R7 no longer resides in the facility. Per Attachment A1 - the turkey and scalloped potato temperatures provided in the citation were within acceptable limits (> 135 F). B. All residents who receive trays in their rooms have the potential to be affected. C. Upon delivery of the cart to each unit, the dietary staff member will obtain a timed signature from a nursing staff member accepting the cart. The nursing staff member will record the time the last tray is delivered on the cart to ensure timely passing of trays. The Food Service Director (FSD) or designee will audit test trays temperatures provided at each meal as well as review the completed delivery form to ensure timely delivery per regulation. D. The FSD will audit test trays at each meal daily for 14 days, weekly times 10, then monthly until 100% compliance is	6/18/18

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	085004	A. BUILDING _____ B. WING _____	C 04/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDYWINE NURSING & REHABILITATION CENTER	505 GREENBANK ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 59 4/24/18 - An observation on the G wing hallway during the lunch meal revealed the following: - at 12:28 PM, an intercom announcement was made that the G wing hallway meal cart was being delivered; - at 12:37 PM, observed the G wing meal delivery cart sitting at the beginning of the G wing hallway unattended; - at 12:45 PM, observed E4 (UM) and E23 (CNA) delivering meal trays in the G wing hallway; - at 12:50 PM, observed 2 meal trays left on the delivery cart to which E23 stated that one resident refused his meal and the surveyor told her the last one was a test tray. - at 12:53 PM, the surveyor's test tray was tested for appetizing temperature and palatability. The surveyor found the meal was not served at an appetizing temperature and the following food items were unpalatable: turkey and scalloped potatoes. The turkey was 139.1 F, broccoli was 134.1 F, scalloped potatoes was 139.7 F, coffee was 145.6 F, milk was 45.0 F, grape juice was 49.1 F, and the apple pie was 47.7 F. 4/25/18 at 2:45 PM - Findings were reviewed with E2 (DON). The facility failed to provide food that was served at an appetizing temperature and palatable. 4/25/18 at 4 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference.	F 804	achieved. Results will be reported at least quarterly through the facility QAPI process.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		6/18/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085004	A. BUILDING _____ B. WING _____	C 04/25/2018

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F 812	Continued From page 60 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and interviews it was determined that the facility failed to ensure storage, preparation, distribution and the serving of food in accordance with professional standards for food service safety. The facility failed to ensure that insulated domes and bases used to serve meals to residents were not in disrepair. 69 out of 144 domes and 50 out of 101 bases were observed in disrepair. Findings include: The following observations and interviews were conducted: 4/20/18 11:53 AM - During a dining observation of the midday meal it was observed that multiple insulated dome plate covers were in disrepair. The outer rims of the dome covers were observed with discoloration and evidence of having surface chipping. The inner aspect of the domes were observed with peeling and/or blistering.	F 812	A. All domes and bases in disrepair have been taken out of service. B. All residents receiving meals have the potential to be affected. C. All domes were replaced by 5/2/18 and the bases which had been placed on back order are expected to be received by 5/18/18. D. All domes and bases will be inspected by the FSD/designee prior to being placed in the drying rack after being run through the dishwasher. Any items found to be worn or in disrepair will immediately be taken out of service. Results will be reported at least quarterly through the facility QAPI process.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 812	Continued From page 61 4/23/18 10:40 AM - Observation in the kitchen of insulated dome plate covers and plate bases revealed them stacked or placed on a ready to use rack in preparation for the midday meal. 69 out of 144 dome covers were observed in disrepair with either fading and chipping of the exterior rim or peeling and/or blistering of the inner surface. 50 out of 101 insulated plate bases were observed in disrepair. 4/23/18 approximately 10:40 AM - During an interview, E22 (Cook) stated that some of the domes and bases had been thrown out and new ones ordered. 4/24/18 approximately 10:30 AM - During an interview, E21 (FSD) stated that approximately 2 to 3 weeks ago he began replacing the plate domes and bases by the dozen, as they were expensive. E21 stated then they received a complaint from a resident's family and so ordered the rest to replace. Review of an email order provided by E21 revealed that on 3/20/18, one case (containing one dozen) each of the dome lids and bases was ordered. Review of an email, dated 4/19/18 (approximately 30 days after the order was first placed), revealed that E21 sent the email to the supplier questioning when the dome lids and bases would be delivered. An email response from the supplier stated that on 4/3/18 and 4/16/18, orders were placed for a dozen domes and bases (total of 2 dozen). A handwritten notation revealed that the 4/3/18 order was received by the facility on 4/21/18. E21 placed an additional order for 3	F 812		

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F 812	Continued From page 62 dozen more domes and bases. Although the facility identified that the plate domes and bases were in disrepair and needed to be replaced, they failed to do so in a timely manner in order to ensure safe food delivery practices. The facility continued to utilize plate domes and bases that were in disrepair that had the potential to contaminate resident's food. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 4/25/18 at approximately 4:00 PM.	F 812		

DELAWARE HEALTH
AND SOCIAL SERVICES
Division of Long Term Care
Residents Protection

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(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Brandywine Nursing & Rehabilitation Center DATE SURVEY COMPLETED: April 25, 2018

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced complaint visit was conducted at this facility from April 11, 2018 through April 25, 2018. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 163. The survey resident sample size was 11. **Abbreviations/definitions used in this state report are as follows:** AE – Agency Employee; CNA – Certified Nurse's Aide; DON- Director of Nursing; E – Employee; LPN – Licensed Practical Nurse; NHA – Nursing Home Administrator.	**Disclaimer Statement:** Preparation and/or execution of this plan of correction (POC) does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The POC is prepared and/or executed solely because it is required by the provisions of both Federal and State laws. Please refer to the electronic POC on the 2567-L survey report submitted via the Aspen web portal for the survey 4/25/18 for F583, F600, F610, F657, F676, F689, F692, F756, F757, F761, F804, and F812.	06-18-2018
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention**		

Provider's Signature _____ Title ADMINISTRATOR Date 5/22/2018

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	Commission are hereby adopted and incorporated by reference. This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed April 25, 2018 F583, F600, F610, F657, F676, F689, F692, F756, F757, F761, F804, and F812.		
Title 16	Delaware Code		
Chapter 11	Nursing Facilities and Similar Facilities		
Subchapter 11.	Minimum Staffing Levels for Residential Health Facilities		
§1162.	(a) Every residential health facility must at all times provide a staffing level adequate to meet the care needs of each resident, including those residents who have special needs due to dementia or a medical condition, illness or injury. Every residential health facility shall post, for each shift, the names and titles of the nursing services direct caregivers assigned to each floor, unit or wing and the nursing supervisor on duty. This information shall be conspicuously displayed in common areas of the facility, in no fewer number than the number of nursing stations. Every residential health facility employee shall wear a nametag prominently displaying his or her full name and title. Personnel hired through temporary agencies shall be required to wear photo identification listing their names and titles.	Example 1 A. AE1 supervisor was contacted and brought a photo identification badge. B. All residents have the potential to be affected by the deficient practice. C. All agency personnel must present appropriate identification to the staffing coordinator/designee prior to start of shift. D. Staff coordinator/designee will document all instances of agency presentation of identification until 100% compliance is achieved daily for 3 months. Results will be reported to the QAPI committee at least quarterly. Example 2 A. AE2 supervisor was contacted and brought a photo identification badge. B. All residents have the potential to be affected by the deficient practice. C. All agency personnel must present appropriate identification to the staffing coordinator/designee prior to start of shift. D. Staff coordinator/designee will document all instances of agency presentation of identification until 100% compliance is achieved daily for 3 months. Results will be reported to the QAPI committee at least quarterly.	06-18-2018 06-18-2018
	Based on observations and interviews it was determined that the facility failed to ensure that facility staff and Agency staff wore appropriate nametags and/or photo identification listing their names and titles.		

Provider's Signature _____ Title ADMINISTRATOR Date 5/22/2018

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	Findings include: 1. Observation on 4/23/18 at 4:20 PM revealed that AE1 was not wearing a photo identification listing her name and title. 2. Observation on 4/23/18 at 4:31 PM revealed that AE2 was not wearing a photo identification listing her name and title. 3. Observation on 4/23/18 at 4:45 PM revealed that AE3 was not wearing a photo identification listing her name and title. 4. Observation on 4/23/18 at 4:40 PM revealed that E24 was not wearing a nametag prominently displaying her full name and title. 5. Observation on 4/24/18 at 11:32 AM revealed that E25 was not wearing a nametag prominently displaying her full name and title.	Example 3 A. AE3 supervisor was contacted and brought a photo identification badge. B. All residents have the potential to be affected by the deficient practice. C. All agency personnel must present appropriate identification to the staffing coordinator/designee prior to start of shift. D. Staff coordinator/designee will document all instances of agency presentation of identification until 100% compliance is achieved daily for 3 months. Results will be reported to the QAPI committee at least quarterly. Example 4 A. E24 was provided with a replacement nametag. B. All residents have the potential to be affected by the deficient practice. C. All staff must present their nametag to their supervisor/designee prior to start of shift. D. Staff coordinator/designee will monitor presentation of all nametags until 100% compliance is achieved daily for 3 months. Results will be reported to the QAPI committee at least quarterly. Example 5 A. E25 was provided with a replacement nametag. B. All residents have the potential to be affected by the deficient practice. C. All staff must present their nametag to their supervisor/designee prior to start of shift. D. Staff coordinator/designee will monitor presentation of all nametags until 100% compliance is achieved daily for 3 months. Results will be reported to the QAPI committee at least quarterly.	06-18-2018 06-18-2018 06-18-2018

Provider's Signature _____ Title ADMINISTRATOR Date 5/22/2018